Medical Leave Request Form: Non-Certified

All medical leave request should be made at least 30 days prior to the date leave is set to begin (if possible). Any medical leave approved will require the use of all applicable paid leave time available to the employee.

Name _____ Phone _____

Job Title/Position _____ Hire

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INDEPENDENT SCHOOL DISTRICT

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Arlington Independent School District
Certification of Health Care Provider Form
Temporary Disability Leave

Employee's name:	Patient's name:
Employee's Department	Employee's Position

The section below should be completed by the Attending Physician or Practitioner:
The information requested on this form relates only to the serious health condition for which the employee is requesting leave.
Please check the applicable category of the patient's qualifying condition:

☐ Hospital Care Admission to Hospital Date: _____ Discharge Date: _____

☐ Serious Health Condition (Absence Plus Treatment)

☐ Birth of a Child Estimated Date of Delivery _____

1. Length of time your patient has had/will have this condition (Keeping the employee from essential functions of his/her job):

   From: _____ Through: _____

2. Describe the health condition and regimen of treatment to be prescribed indicating the number of visits, general nature and duration of treatment, and including referral to other provider(s) of health services.

Print of Type Name of Healthcare provider:	
Type of Practice:	
Street & Mailing Address:	
Telephone Number:	Fax Number:
Signature of Healthcare Provider:	Date:

Return form to: HR Leaves
Email: SZKLWHVL@aisd.net Fax: (682) 867-4258
Arlington ISD Benefits, 1203 W. Pioneer Pkwy., Arlington, TX 76013

ARLINGTON INDEPENDENT SCHOOL DISTRICT
FITNESS-FOR-DUTY CERTIFICATION
(To be submitted prior to reinstatement)

Employee Name: _____Position_____

Campus/Department: _____

Employee's serious health condition which caused him/her to take □ □ □ □□ □ leave □ □ □□ □□ :

HIPAA AUTHORIZATION FORM

Employee's Full Name	**Social Security Number**
Address	**Employee ID Number**
City, State Zip Code	**Date of Birth**
Telephone Number	**Email**

I authorize the use or disclosure of my protected health information as described below.

1. The specific information that should be disclosed is (please give dates of service if possible):

   FMLA and/or Extended leave status updates
2. The following person (or class of persons) is authorized to use or disclose my protected health information:

   Arlington Independent School District Benefits Department
3. The following person (or class of persons) may receive disclosure of protected health information about me:

   Arlington Independent School District Benefits Department

I understand that the use of disclosure of the requested information in this a